GREENVINE HEALTHCARE

ESTABLISHED PATIENT ANNUAL EXAM QUESTIONNAIRE

Demographics:	
Name:	Date of Birth:
Address:	Social Security Number:
Who was your primary care provider?	
Employer:	
Insurance:	
Please list any other health care providers you see regularly and their specialty:	

MEDICATIONS: Please list (or show us your own printed record) of all prescriptions and non-prescription medications you are taking. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter medications, etc.

Medication	Dose	How many times per day

ALLERGIES or intolerance to medications?

Medication/Food/Misc	Reaction

IMMUNIZATIONS since your last visit:	
Tetanus (Td)	Tetanus (Tdap)
Varicella (shot or illness)	Pneumovax (pneumonia)
Influenza (flu shot)	Hepatitis A
Hepatitis B	MMI
Meningitis	Zostavax/Shingrix (shingles)
HPV	COVID

HEALTH MAINTENANCE SCREENING TESTS since your last visit:	
Lipid (cholesterol)	Sigmoidoscopy or colonoscopy
PSA (blood prostate screening)	Mammogram
PAP Smear	Bone Density Testing
Provider:	Date:

PERSONAL MEDICAL HISTORY: Do you have now or have you had in the past any of the following?			
Condition	**Yes**	**No**	**Comments**
Abnormal PAP smear			
Alcohol/Drug Abuse			
Allergies (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid/Osteoarthritis)			
Asthma			
Bladder/Kidney Problems			
Blood Clot (leg/lung)			
Blood Transfusion			
Breast Lump (benign)			
Cancer Location:			
Cataracts			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Dementia			
Diabetes (adult or childhood onset)			
Diverticulosis			
Emphysema (COPD)			
Endometriosis			
Fibroids (Uterine)			
Fractures (broken bones)			
Gallbladder Disease			
Gastroesophageal Reflux (Heartburn/GERD)			
Glaucoma			
Gout			
Heart Attack			
Hepatitis Type: A B C Other			
High Blood Pressure			
High Cholesterol			
Irritable Bowel Syndrome			
Kidney Disease/Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate Enlargement or Nodules			
Seizures/Epilepsy			
Skin Issues Eczema/Psoriasis/Abnormal Moles			
Sleep Apnea			
Stomach Ulcers			
Stroke			
Thyroid Disease or Nodules			
Other:			
Other:			
Other:			
Provider:		Date:	

SURGICAL AND PROCEDURAL HISTORY: Please check off any procedures/surgeries.

Surgical Procedure	Year	Comments
Abdominal Surgery		
Angiogram (heart)		
Angiogram (vascular)		
Appendectomy		
Back Surgery		
Biopsy		
Breast Surgery		
Cataract Surgery		
Colonoscopy		
Coronary Bypass		
Coronary Stent		
Cesarean Section		
Echocardiogram (heart)		
EGD (stomach endoscopy)		
Gallbladder Removal		
Heart Surgery		
Hip Surgery		
Hysterectomy Partial/Complete/Total		
Joint Replacement		
Knee Surgery		
LEEP (cervix surgery)		
Neck Surgery		
Pulmonary Function Test		
Sigmoidoscopy		
Sinus Surgery		
Stress Test (cardiac)		
Tonsillectomy		
Tubal Ligation		
Vasectomy		
Other:		
Other:		
Other:		
Other:		
Other:		

HEALTH ISSUES:

Tobacco Use: Yes No If yes, please complete the following:

What do you smoke (Please circle one): Cigarettes Cigars Pipe Other:________________

How long have you been smoking: ________________ years

How much do you smoke per day: ________________ packs or each

Calculated pack history: ________________

Alcohol Use: Yes No If yes, please complete the following:

How much do you drink?

Beer Number per week: ________________ Bottles/Cans

Wine Number per week: ________________ Glass/Bottles

Liquor Number per week: ________________ Drinks/Bottles

What do you drink?

Beer Number per week: ________________ Bottles/Cans

Wine Number per week: ________________ Glass/Bottles

Liquor Number per week: ________________ Drinks/Bottles

Drug Use:

Have you **ever** used illicit or legal drugs recreationally? Yes No Current use? Yes No

Which ones?: ____

Provider: Date:

HEALTH AND SAFETY: (Please circle one)

Does your home have working smoke detector? Yes No

Does your home have working carbon monoxide detector if gas is in the home? Yes No N/A

Do you have guns in your home? Yes No If yes, are they locked up/secured? Yes No

Have you or any family members ever been hurt, insulted, threatened or screamed at? Yes No

Do you wear a seat belt when in a vehicle? Yes No

Do you wear a helmet or protective gear when appropriate? Yes No

Do you exercise regularly? Yes No

Do you follow a special diet? Yes No Please describe if yes:

SEXUAL HISTORY:

Are you sexually active? Yes No

Sexual partners are/have been/may be in future: Female Male Both

Birth control method/sexually transmitted disease prevent: (Please circle all that apply)
None Barrier Method Pill IUD Patch Ring Diaphragm
Tubal Ligation Vasectomy Other: (specify)

WOMEN'S HEALTH:

Total # of pregnancies: Total # of births: # of miscarriages: # of abortions:

Age at the beginning or menstruation:

How often do periods occur? Every ________ days How long do they last? ________ days

How heavy are your periods? Heavy with clots Moderate Light Cramping? Yes No

Age at end of periods (menopause/hysterectomy)

Do you have concerns about your periods or menopause you'd like to discuss? Yes No

SOCIOECONOMIC:

Marital Status: (Please circle one) Single Partner Married Divorced Widow(er)

Education: High school or GED Trade school College Graduate school Other

MEDICAL FORMS:

Do you have Advance Directive for Health Care (ADHC)? Yes No

Do you have Durable Power of Attorney for Healthcare Decisions? Yes No

Do you have a Living Will? Yes No

Do you know about these or have the forms but have not completed them? Yes No

Don't know what these are? Yes No

Provider Comments after review:

Provider:	Date:

FAMILY HISTORY:

Family Member	Maternal grandmother	Maternal grandfather	Paternal grandmother	Paternal grandfather	Mother	Father	Brother	Brother	Brother	Sister	Sister	Sister	Son	Son	Daughter	Daughter
Alive(A)/ Deceased (D) (Please circle one)	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased
CONDITION:																
Adopted/Unknown family history																
No significant history																
Alcoholism/Drug Abuse																
Alzheimer's																
Asthma																
Autoimmune Disease																
Bleeding or Clotting Disorder																
Cancer, Breast																
Cancer, Colon																
Cancer, Lung																
Cancer, Ovarian																
Cancer, Other																
Cancer, Prostate																
Colon Polyp																
Depression																
Diabetes – Insulin dependent																
Diabetes Type II Adult onset																
Emphysema																
Genetic Disorder																
Glaucoma																
Heart Attack, Angina, Coronary Heart Disease																
Heart Disease, Congestive Heart Failure																
Heart Disease, Other																
Hepatitis B or C																
Hip Fracture																
Hyperlipidemia																
Hypertension																
Hyperthyroidism																
Hypothyroidism																
Kidney Disease																
Kidney Stone																
Macular Degeneration																
Osteoporosis																
Stroke																
Sudden Cardiac Death																
Thyroid Disease																
Other																
Other																
Other																
Other																
Other																

Provider comments:

Provider: Date:

GREENVILLE HEALTH CARE

Patient Name: ______________________________ DOB: ____________

Physical Functional Ability Questionnaire (FAQ5)

(Please circle the number in each of the questions which best summarizes your ability)

Self-care ability assessment:

1. Require total care – for bathing, toilet, dressing, moving and eating
2. Require frequent assistance
3. Require occasional assistance
4. Independent with self-care

Family and social ability assessment:

1. Unable to perform any chores, hobbies, driving, sex, and social activities
2. Able to perform some
3. Able to perform many
4. Able to perform all

Movement ability assessment:

1. Able to get up and walk with assistance, unable to climb stairs
2. Able to get up and walk independently, able to climb one flight of stairs
3. Able to walk short distances and climb more than one flight of stairs
4. Able to walk long distances and climb stairs without difficulty

Lifting ability assessment:

1. Able to lift up to 10# occasionally
2. Able to lift up to 20 # occasionally
3. Able to lift up to 50# occasionally
4. Able to lift over 50# occasionally

Work ability assessment:

1. Unable to do any work.
2. Able to work part-time and with physical limitations
3. Able to work part-time or with physical limitations
4. Able to perform normal work.

To be completed by provider.

Physical Functional Ability Score: ____________

Reviewed by provider and discussed with patient:

Provider: ______________________________ Date: ____________

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GREENVILLE HEALTHCARE

Patient Name: ______________________________ DOB: ____________

Patient Health Questionnaire (PHQ-(9)

(Please circle your response)

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed, or hopeless	0	1	2	3
c. Trouble falling/staying asleep, sleeping too much	0	1	2	3
d. Feeling tired or having little energy	0	1	2	3
e. Poor appetite or overeating	0	1	2	3
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
i. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3
If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	0	1	2	3

To be completed by provider.

Total Score: ____________

Reviewed by provider and discussed with patient:

Provider: ______________________________ Date: ____________

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